

CHAPTER 4

THE 1949 GENEVA CONVENTION ON WOUNDED AND SICK IN THE FIELD

References

1. I Geneva Convention for the Amelioration of the Condition of Wounded and Sick in Armed Forces of the Field, August 12, 1949, T.I.A.S. 3362. (GWS)
2. II Geneva Convention for the Amelioration of the Condition of Wounded, Sick, and Shipwrecked Members of Armed Forces at Sea, August 12, 1949, T.I.A.S. 3363. (GWS (Sea))
3. The 1977 Protocols Additional to the Geneva Conventions, December 12, 1977, 16 I.L.M. 1391, DA Pam 27-1-1. (GP I & II)
4. I Commentary on the Geneva Conventions (Pictet ed. 1960).
5. Dept. of Army, Pamphlet 27-1, Treaties Governing Land Warfare (7 December 1956).
6. Dept. of Army, Pamphlet 27-1-1, Protocols to The Geneva Conventions of 12 August 1949 (1 September 1979).
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8. Dept. of Army, Field Manual 27-10, The Law of Land Warfare (18 July 1956).
9. Dept. of Army, Field Manual 8-10, Health Service Support in a Theater of Operations (1 March 1991).
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12. Morris Greenspan, THE MODERN LAW OF LAND WARFARE (1959).
13. Dietrich Schindler & Jiri Toman, THE LAW OF ARMED CONFLICT (1988).
14. Hilaire McCoubrey, INTERNATIONAL HUMANITARIAN LAW (1990).
15. Howard S. Levie, THE CODE OF INTERNATIONAL ARMED CONFLICT (1986).
16. Alma Baccino-Astrada, MANUAL ON THE RIGHTS AND DUTIES OF MEDICAL PERSONNEL IN ARMED CONFLICTS (1982).

I. INTRODUCTION.

A. Definition.

1. The term “Wounded and Sick” is not defined in the GWS. Concerned that any definition would be misinterpreted, the drafters decided that the meaning of the words was a matter of “common sense and good faith.” Pictet, *supra*, at 136.

2. However, Article 8(a), Protocol I, contains the following widely accepted definition: “Persons, whether military or civilian, who, because of trauma, disease or other physical or mental disorder or disability, are in need of medical assistance or care and who refrain from any act of hostility.”
 3. GWS (Sea) applies same protections to those “shipwrecked” at sea - shipwrecked meaning “shipwreck from any cause and includes forced landings at sea by or from aircraft.” (Art. 12). Article 8(b), Protocol I provides a more detailed definition of “shipwrecked” which is similar to the “wounded and sick” definition above. Once put ashore, “shipwrecked” forces become “wounded and sick” forces under the GWS. (GWS (Sea), Art. 4)
- B. Scope of Application. For the protected persons who have fallen into the hands of the enemy, the GWS applies until their final repatriation. (GWS, Art. 5)

II. CATEGORIES OF WOUNDED AND SICK.

- A. Protected Persons (Article 13) - same as Article 4, GPW.
1. Members of armed forces of a Party to the conflict, . . . militias [and] volunteer corps forming part of such armed forces.
 2. Members of other militias and members of other volunteer corps, including those of organized resistance movements, belonging to a Party to the conflict . . . provided [they] fulfil the following conditions:
 - a. that of being commanded by a person responsible for his subordinates;
 - b. that of having a fixed distinctive sign recognizable at a distance;
 - c. that of carrying arms openly;
 - d. that of conducting their operations in accordance with the laws and customs of war.
 3. Members of regular armed forces who profess allegiance to a government or an authority not recognized by the Detaining Power.

4. Persons who accompany the armed forces without actually being members thereof . . . provided they have received authorization from the armed forces which they accompany. . . .
5. Members of crews . . . of the merchant marine and . . . civil aircraft of the Parties to the conflict, who do not benefit by more favorable treatment under any other provisions of international law.
6. Inhabitants of a non-occupied territory, who on the approach of the enemy spontaneously take up arms to resist the invading forces . . . provided they carry arms openly and respect the laws and customs of war.

B. Civilians.

1. Not expressly covered by GWS - but have general protection as noncombatants - may not be targeted.
2. Express coverage is found, however, in the Geneva Civilians Conventions (GC), Article 16: “The wounded and sick, as well as the infirm, and expectant mothers, shall be the object of particular protection and respect.” *See* G.I.A.D. Draper, *THE RED CROSS CONVENTIONS OF 1949* 74 (1958).
3. Article 8(a), Protocol I (GP I) expressly included civilians within its definition of “wounded and sick.”
4. Thus, as a practical matter, all wounded and sick, military and civilian, in the hands of the enemy must be respected and protected. FM 27-10, *supra*, at para. 208; FM 8-10, *supra*, para. 3-17.

III. THE HANDLING OF THE WOUNDED AND SICK.

A. Protection (Article 12).

1. General - “Members of the armed forces and other persons mentioned in the following Article, who are wounded or sick, shall be respected and protected in all circumstances.”
 - a. Respect - to spare, not to attack.

(1) During the Vietnam conflict there were several examples of violations of this prohibition, e.g., during the November 1965 battle in Ia Drang Valley pitting regular North Vietnamese (NVA) units against units of the 1st Cavalry Division there were several accounts of NVA personnel shooting wounded Americans lying on the battlefield. Moore, *WE WERE SOLDIERS ONCE AND YOUNG* (1993).

(2) During the Falklands War, international humanitarian law was generally well followed but there was an incident where two lightly armed British helos accompanying a supply ship were shot down and Argentinean forces continued to fire on the helo crewmen as they struggled in the water. Three of the crewmen were killed, and the fourth was wounded. Soon after this incident an Argentinean flyer was shot down. British leadership ensured proper treatment despite some reprisal suggestions. Robert Higginbotham, *Case Studies in the Law of Land Warfare II: The Campaign in the Falklands*, *Military Review* 52-53 (Oct 1984).

b. Protect - to come to someone's defense; to lend help and support.

(1) A excellent example of this concept occurred in the Falklands when a British soldier came upon a gravely wounded Argentinean whose brains were leaking into to his helmet. The British soldier scooped the extruded material back into the soldier's skull and evacuated him. The Argentinean survived. Higginbotham, *supra*, at 50.

(2) Extent of Obligation - It is "unlawful for an enemy to attack, kill, ill treat or in any way harm a fallen and unarmed soldier, while at the same time . . . the enemy [has] an obligation to come to his aid and give him such care as his condition require[s]." Pictet, *supra*, at 135.

B. Care (Article 12).

1. Standard is one of humane treatment - "[E]ach belligerent must treat his fallen adversaries as he would the wounded of his own army." Pictet, *supra*, at 137.

2. No adverse distinctions may be established in providing care.

- a. May not discriminate against wounded or sick because of “sex, race, nationality, religion, political opinions, or any other similar criteria.”
 - b. Note the use of the term “adverse” permits favorable distinctions, e.g., taking physical attributes into account, such as in the case of children, pregnant women, the aged, etc..
3. The wounded and sick “shall not willfully be left without medical assistance and care, nor shall conditions exposing them to contagion or infection be created.”
- a. The first prohibition stems from a recognition that wounded personnel, who had not yet received medical treatment, “were profitable subjects for interrogation.” Draper, *supra*, at 76. Professor Draper cites the German practice during World War II at their main aircrew interrogation center. They frequently delayed medical treatment until after interrogation. Such conduct is now expressly forbidden.
 - b. The second prohibition was designed to counter the German practice of sealing off Russian PW camps once typhus or tuberculosis was discovered. Best, *supra*, at 134.

C. Order of Treatment (Article 12).

- 1. Determined solely by reasons of medical urgency. Designed to strengthen the principle of equal treatment articulated above.
 - a. Treatment is accorded using triage principles which provide the greatest medical assets to those with significant injuries who may benefit from treatment, while those wounded who will die no matter what and those whose injuries are not serious are given lesser priority.
 - b. The US applies this policy at the evacuation stage, as well as at the treatment stage. “Sick, injured, or wounded EPWs are treated and evacuated through normal medical channels, but are physically segregated from US or allied patients. The EPW patient is evacuated from the combat zone as soon as his medical condition permits.” Dep’t of Army Field Manual 8-10-6, Medical Evacuation in a Theater of Operations, appendix A-1 (31 October 1991).

- c. During Operation JUST CAUSE, wounded Panamanian Defense Force personnel were evacuated on the same aircraft as US personnel and provided the same medical care as US forces. Lessons Learned: Operation JUST CAUSE, Unclassified Executive Summary, p. 7 (24 May 1990) (on file at TJAGSA).
 - d. In the Falklands the quality of medical care provided by the British to the wounded, without distinction between British and Argentinean, was remarkable. More than 300 major surgeries were performed, and 100 of these were on Argentinean soldiers. Higginbotham, *supra*, at 50.
 - e. Unfortunately, as pointed out by Professor Levie citing the example of the Japanese during World War II, “this humanitarian procedure [referring to treating enemy wounded like your own] is far from being universally followed.” Howard S. Levie, PRISONERS OF WAR IN INTERNATIONAL ARMED CONFLICT, 100 (1976).
2. Medical personnel must make the decisions regarding medical priority on the basis of their medical ethics. Baccino-Astrada, *supra*, at 40. This standard is reiterated in Article 10, Protocol I for emphasis.

D. Abandoning Wounded and Sick to the Enemy (Article 12).

1. If, during a retreat, a commander is forced to leave behind wounded and sick, he is required to leave behind medical personnel and material to assist in their care.
2. “[A]s far as military considerations permit” – provides a limited military necessity exception to this requirement. Thus a commander need not leave behind medical personnel if such action will leave his unit without adequate medical staff. Nor can the enemy refuse to provide medical care to abandoned enemy wounded on the grounds that the enemy failed to leave behind medical personnel. The detaining power ultimately has the absolute respect and protect obligation. Pictet, *supra*, at 142.

E. Status of Wounded and Sick (Article 14).

1. The wounded or sick soldier enjoys the status of a PW. Actually the soldier will be protected under both the GWS and the GPW until recovery is complete, at which time the soldier is exclusively governed by the GPW.

2. While the conventions overlap, i.e., during the treatment and recovery phase, the GWS takes precedence. But, as Pictet states, this is an academic point as the protections in both are largely the same. Pictet, *supra*, at 147.

F. Search for Casualties (Article 15).

1. Search, Protection, and Care.

- a. “At all times, and particularly after an engagement.” Parties have an ongoing obligation to search for the wounded and sick as conditions permit. The commander determines when it is possible to do so. This mandate applies to all casualties, not just friendly casualties.

(1) The drafters recognized that there were times when military operations would make the obligation to search for the fallen impracticable. Pictet, *supra*, at 151.

(2) By way of example, US policy during Operation DESERT STORM was not to search for casualties in Iraqi tanks or armored personnel carriers because of concern about unexploded ordnance.

(3) Similar obligations apply to maritime operations (Article 18, GWS (Sea)). It was through this military necessity exception that HMS Conqueror did not assist the shipwrecked members of the Argentinean cruiser General Belgrano after its torpedo attack against it. The Conqueror was reasonably concerned about the threat of a destroyer attack if it lingered in the area. Admiral Sandy Woodward, ONE HUNDRED DAYS 162 (1992). Professor Draper explicitly states that “[I]t is apparent that submarines will rarely be in a position to search for and collect the wounded or shipwrecked. Neither has such a craft the facilities for ensuring their adequate care. Further, the search for shipwrecked by even larger ships is operationally a very dangerous proceeding, exposing the search vessel to the grave risk of submarine attack by day or night and to air attack by day.” Draper, *supra*, at 87.

- b. The protection requirement refers to preventing pillage of the wounded by the “hyenas of the battlefield.”
- c. Care refers to the requirement to render first aid.

- d. Note that the search obligation also extends to searching for the dead, again, as military conditions permit. During the Falklands War the Argentineans were scrupulous in handling of the dead. A Harrier pilot was killed over Goose Green and buried with military honors. Higginbotham, *supra*, at 51.

2. Suspensions of Fire and Local Agreements.

- a. Suspensions of fire are agreements calling for cease-fires that are sanctioned by the Convention to permit the combatants to remove, transport, or exchange the wounded, sick and the dead (note that exchanges of wounded and sick between parties did occur to a limited extent during World War II, Pictet, *supra*, at 155).
- b. Suspensions of fire were not always possible without negotiation and, sometimes, the involvement of staffs up the chain of command. Consequently, local agreements, an innovation in the 1949 convention to broaden the practice of suspensions of fire by authorizing similar agreements at lower command levels, are sanctioned for use by local on-scene commanders to accomplish the same function.
- c. Article 15 also sanctions local agreements to remove or exchange wounded and sick from a besieged or encircled area, as well as the passage of medical and religious personnel and equipment into such areas. The GC contains similar provisions for civilian wounded and sick in such areas. It is this type of agreement that has been used to permit the passage medical supplies to the city of Sarajevo during the siege of 1992.

G. Identification of Casualties (Articles 16-17).

1. Parties are required, as soon as possible, to record the following information regarding the wounded, sick, and the dead: name, ID number, DOB, date and place of capture or death, and particulars concerning wounds, illness, or cause of death.
2. Forward information to Prisoners of War Information Bureau (*See* Article 122, GPW). Information Bureaus are established by Parties to the conflict to transmit and to receive information/articles regarding PWs to/from the ICRC's Central Tracing Agency. The US employs the National PW Information Center (NPWIC) in this role.

3. In addition, Parties are required to forward the following information and materials regarding the dead:
 - a. Death certificates.
 - b. ID disc.
 - c. Important documents, e.g., wills, money, etc., found on the body.
 - d. Personal property found on the body.
4. Handling of the Dead.
 - a. Examination of bodies (a medical examination, if possible) to confirm death and to identify the body. Such examinations can play a dispositive role in refuting allegations of war crimes committed against individuals. Thus, they should be conducted with as much care as possible.
 - b. No cremation (except for religious or hygienic reasons).
 - c. Honorable burial. Individual burial is strongly preferred; however, there is a military necessity exception which permits burial in common graves, e.g., if circumstances, such as climate or military concerns, necessitate it. Pictet, *supra*, at 177.
 - d. Mark and record grave locations.

H. Voluntary Participation of Local Population in Relief Efforts (Article 18).

1. Commanders may appeal to the charity of local inhabitants to collect and care for the wounded and sick. Such actions by the civilians must be voluntary. Similarly, commanders are not obliged to appeal to the civilians.
2. Spontaneous efforts on the part of civilians to collect and care for the wounded and sick is also permitted.
3. Ban on the punishment of civilians for participation in relief efforts. This provision arose from the fact that the Germans prohibited German civilians from aiding wounded airmen.

4. Continuing obligations of occupying power. Thus, the occupant cannot use the employment of civilians as a pretext for avoiding their own responsibilities for the wounded and sick. The contribution of civilians is only incidental. Pictet, *supra*, at 193.
5. Civilians must also respect the wounded and sick. This is the same principle discussed above (article 12) vis-à-vis armed forces. This is the only article of the convention that applies directly to civilians. Pictet, *supra*, at 191.

IV. STATUS AND PROTECTION OF PERSONNEL AIDING WOUNDED AND SICK.

A. Categories of Persons Protected Based Upon Rights Possessed.

1. **The first category:** (Article 24) Medical personnel exclusively engaged in the search for, or the collection, transport or treatment of the wounded or sick, or in the prevention of disease; staff exclusively engaged in the administration of medical units and establishments; chaplains; and personnel of national Red Cross/Crescent Societies and other recognized relief organizations (Article 26).
 - a. Respect and protect (Article 24) - applies “in all circumstances.” In Vietnam US soldiers claimed that the NVA and Vietcong targeted medical personnel because of their importance in maintaining morale. So they’d shoot medics even if they were giving care. Consequently medics often avoided wearing armbands which acted as bulls-eyes. There were even reports that the Vietcong paid an incentive for killing medics. Eric M. Bergerud, *RED THUNDER, TROPIC LIGHTNING: THE WORLD OF A COMBAT DIVISION IN VIETNAM* 201-03 (1993).
 - b. Status upon capture (Article 28) - **Retained Personnel**, not PWs.
 - (1) A new provision in the 1949 convention. The 1864 and 1906 conventions required immediate repatriation. The 1929 convention also required repatriation, absent an agreement to retain medical personnel. During World War II, the use of these agreements became extensive, and very few medical personnel were repatriated. Great Britain and Italy, for example, retained 2 doctors, 2 dentists, 2 chaplains, and 12 medical orderlies for every 1,000 PWs.

- (2) The 1949 convention institutionalized this process. Some government experts proposed making medical personnel straight PWs, the idea being that wounded PWs prefer to be cared for by their countrymen, speaking the same language. The other camp, favoring repatriation, cited the traditional principle of inviolability—that medical personnel were non-combatants. What resulted was a compromise: medical personnel were to be repatriated, but if needed to treat PWs, they were to be retained and treated, at a minimum, as well as PWs. Pictet, *supra*, at 238-40.
 - (3) Note that medical personnel may only be retained to treat PWs. Under no circumstances may they be retained to treat enemy personnel. While the preference is for the retained persons to treat PWs of their own nationality, the language is sufficiently broad to permit retention to treat **any** PW. Pictet, *supra*, at 241.
- c. Repatriation of Medical Personnel (Articles 30-31).
- (1) Repatriation is the rule; retention the exception. Medical personnel are to be retained only so long as required by the health and spiritual needs of PWs and then are to be returned when retention is not indispensable. Pictet, *supra*, at 260-61.
 - (2) Article 31 states that selection of personnel for return should be irrespective of race, religion or political opinion, preferably according to chronological order of capture—first-in/first-out approach.
 - (3) Parties may enter special agreements regarding the percentage of personnel to be retained in proportion to the number of prisoners and the distribution of the said personnel in the camps. The US practice is that retained persons will be assigned to PW camps in the ratio of 2 doctors, 2 nurses, 1 chaplain, and 7 enlisted medical personnel per 1,000 PWs. Those not required will be repatriated. *See*, AR 190-8/OPNAVINST 3461.6/AFJI 31-304/MCO 3461.1, Enemy Prisoners of War, Retained Personnel, Civilian Internees and Other Detainees, 1 November 1997.
 - (4) Since World War II, this is one of the least honored provisions of the convention. US medical personnel in Korea and Vietnam were not only not repatriated, but were also denied retained person

status. Memorandum of W. Hays Parks to Director, Health Care Operations *reprinted in* The Army Lawyer, April 1989, at 5.

- d. Treatment of Medical Personnel(Article 28).
 - (1) May only be required to perform medical and religious duties.
 - (2) Receive at least all benefits conferred on PWs, e.g., pay, monthly allowances, correspondence privileges. AR 190-8 etc., *supra*.
 - (3) Are subject to camp discipline.
 - e. Relief (Article 28). Belligerents may relieve doctors retained in enemy camps with personnel from the home country. During World War II some Yugoslavian and French doctors in German camps were relieved. Pictet, *supra*, at 257.
 - f. Continuing obligation of detaining power (Article 28). The detaining power is bound to provide free of charge whatever medical attention the PWs require.
2. **The second category:** Auxiliary medical support personnel of the Armed Forces (Articles 25 & 29).
- a. These are personnel who have received special training in other medical specialties, e.g., orderlies, nurses, stretcher bearers, in addition to performing other military duties.
 - b. Respect and protect (Article 25) - when acting in medical capacity.
 - c. Status upon capture (Article 29) - PWs; however, must be employed in medical capacity insofar as a need arises.
 - d. Treatment (Article 29).
 - (1) When not performing medical duties, treat as PWs.
 - (2) When performing medical duties, they remain PWs, but receive treatment under Article 32, GPW, as retained personnel; however, they are not entitled to repatriation.
 - (3) Auxiliaries are not widely used, but see W. Hays Parks memorandum, *supra*, (in materials) for discussion of certain US

personnel, who *de facto*, become auxiliary personnel. *See also* FM 8-10, *supra*, at para. 3-18b (discusses this same issue and points out that Article 24 personnel switching between medical and non-medical duties **at best** places such individuals in the auxiliary category).

(4) The US Army does not employ any auxiliary personnel. FM 8-10, *supra*, at para. 3-18. Air Force regulations do provide for these personnel. *See* Bruce T. Smith, Air Force Medical Personnel and the Law of Armed Conflict, 37 A. F. L. Rev. 242 (1994).

3. **The third category:** Personnel of aid societies of neutral countries (Articles 27 & 32).

a. Nature of assistance: procedural requirements (Article 27).

(1) Consent of neutral government.

(2) Consent of party being aided.

(3) Notification to adverse party.

b. Retention prohibited (Article 32) - must be returned “as soon as a route for their return is open and military considerations permit.”

c. Treatment pending return (Article 32) - must be allowed to perform medical work.

V. MEDICAL UNITS AND ESTABLISHMENTS.

A. Protection.

1. Fixed Establishments and Mobile Medical Units (Article 19).

a. May not be attacked.

(1) In Afghanistan, the Soviets engaged in a campaign to destroy hospitals and dispensaries operated by non-governmental organizations (Medecins sans Frontieres, Medecins du Monde, Aide Medicale Internationale - all NGOs comprised of French doctors and nurses). In September of 1980, the Soviets sacked the hospital at Yakaolang, even destroying all medical supplies and equipment. In late 1981 the Soviets systematically bombed

hospitals operated by French medical organizations. At least 8 hospitals of the three NGOs above were hit. One was rebuilt with a prominent red cross, but was still bombed again by Russian helos. Helsinki Watch, TEARS, BLOOD, AND CRIES, HUMAN RIGHTS IN AFGHANISTAN SINCE THE INVASION 1979-1984, at 184-6.

(2) In Vietnam during the 1968 Tet offensive, communist forces attacked the 45th MASH at Tay Ninh, killing one doctor and two medics. Bergerud, *supra*, at 206.

- b. Commanders are encouraged to situate medical units and establishments away from military objectives. See also Article 12, GP I, which states that medical units will, in no circumstances, be used to shield military objectives from attack.
 - c. If these units fall into the hands of an adverse party, medical personnel will be allowed to continue caring for wounded and sick.
2. Discontinuance of Protection (Article 21).
- a. These units/establishments lose protection if committing “acts harmful to the enemy.” Pictet cites as examples such acts as using a hospital as a shelter for combatants, as an ammunition dump, or as an observation post. Pictet, *supra*, at 200-01.
 - b. Protection ceases only after a warning has been given and it remains unheeded after a reasonable time to comply. A reasonable time varies on the circumstances, e.g., no time limit would be required if fire is being taken from the hospital. Pictet, *supra*, at 202.
 - c. Article 13, GP I, extends this same standard to civilian hospitals.
3. Conditions not depriving medical units and establishments of protection (Article 22).
- a. Unit personnel armed for own defense against marauders and those violating the law of war, e.g., by attacking a medical unit. Medical personnel thus may carry small arms, such as rifles or pistols for this purpose. In contrast, placing machine guns, mines, LAAWS, etc., around a medical unit would cause a loss of protection. FM 8-10, *supra*, at para. 3-21.

- b. Unit guarded by sentries. Normally medical units are guarded by its own personnel. It will not lose its protection, however, if a military guard attached to a medical unit guards it. These personnel may be regular members of the armed force, but they may only use force in the same circumstances as discussed in para 3(a) above. FM 8-10, *supra*, at para. 3-21.
 - c. Small arms taken from wounded are present in the unit.
 - d. Presence of personnel from the veterinary service.
 - e. Provision of care to civilian wounded and sick.
- B. Disposition of Captured Buildings and Material of Medical Units and Establishments.
- 1. Mobile Medical Units (Article 33).
 - a. Material of mobile medical units, if captured, need not be returned. This was a significant departure from the 1929 convention which required mobile units to be returned.
 - b. But captured medical material must be used to care for the wounded and sick. First priority for the use of such material are the wounded and sick in the captured unit. If there are no patients in the captured unit, the material may be used for other patients. Pictet, *supra*, at 274; *see also* FM 8-10, *supra*, at para. 3-19.
 - 2. Fixed Medical Establishments (Article 33).
 - a. The captor has no obligation to restore this property to the enemy - he can maintain possession of the building, and its material becomes his property. However, the building and the material must be used to care for wounded and sick as long as requirement exists. Morris Greenspan, *THE MODERN LAW OF LAND WARFARE* 85 (1959).
 - b. Exception - “in case of urgent military necessity,” they may be used for other purposes.
 - c. If a fixed medical establishment is converted to other uses, prior arrangements must be made to ensure that wounded and sick are cared for.

3. Medical material and stores of both mobile and fixed establishments
“shall not be intentionally destroyed.” **No military necessity exception.**

VI. MEDICAL TRANSPORTATION.

A. Medical Vehicles - Ambulances (Article 35).

1. Respect and protect - may not be attacked if performing a medical function. During the Bosnian conflict, there were several reports of attacks on medical vehicles, e.g., on June 24, 1992, Bosnian Serb machine gunners fired on two ambulances killing all six occupants. Helsinki Watch, *WAR CRIMES IN BOSNIA-HERCEGOVINA* 115 (1992).
2. These vehicles may be employed permanently or temporarily on such duties and they need not be specially equipped for medical purposes. Pictet, *supra*, at 281. Professor Draper states that “[a]s ambulances are not always available, any vehicles may be adapted and used temporarily for transport of the wounded. During that time they will be entitled to protection, subject to the display of the distinctive emblem. Thus military vehicles going up to the forward areas with ammunition may bring back the wounded, with the important reservation the emblem must be detachable, e.g., a flag, so that it may be flown on the downward journey. Conversely military vehicles may take down wounded and bring up military supplies on the return journey. The flag must then be removed on the return journey.” Draper, *supra*, at 83.
3. Key issue for these vehicles is the display of the distinctive emblem, which accords them protection.
 - a. Camouflage scenario: Belligerents are only under an obligation to respect and protect medical vehicles so long as they can identify them. Consequently, absent the possession of some other intelligence regarding the identity of a camouflaged medical vehicle, belligerents would not be under any obligation to respect and protect it. FM 8-10, *supra*, at para. 3-19. *See also* Draper, *supra*, at 80.
 - b. Display the emblem only when the vehicle is being employed on medical work. Misuse of the distinctive symbol is a war crime. FM 27-10, *supra*, at para. 504.
4. Upon capture, these vehicles are “subject to the laws of war.”

- a. Thus, the captor may use them for any purpose.
- b. If the vehicles are used for non-medical purposes, the captor must ensure care of wounded and sick they contained, and, of course, ensure that the distinctive markings have been removed.

B. Medical Aircraft (Article 36).

1. Definition - Aircraft exclusively employed for the removal of wounded and sick and for the transport of medical personnel and equipment.
2. Protection.
 - a. Marked with protected emblem.
 - b. However, protection ultimately depends on an agreement: medical aircraft are not be attacked if “flying at heights, times and on routes specifically agreed upon between the belligerents.” The differing treatment accorded to aircraft, as opposed to ambulances, is a function of their increased mobility and consequent heightened fears about their misuse. Also “the speed of modern aircraft makes identification by colour or markings useless. Only previous agreement could afford any real safeguard.” Draper, *supra*, at 84.
 - c. Without such an agreement, belligerents use medical aircraft at their own risk. Pictet, *supra*, at 288; FM 8-10, *supra*, at para. 3-19.
 - (1) This was certainly the case in Vietnam where “any air ambulance pilot who served a full one year tour could expect to have his aircraft hit at least once by enemy fire.” “Most of the Viet Cong and North Vietnamese clearly considered the air ambulances just another target.” Dorland & Nanney, DUST OFF: ARMY AEROMEDICAL EVACUATION IN VIETNAM 85-86 (1982)(although the authors note the pilot error and mechanical failure accounted for more aircraft losses than did hostile fire).
 - (2) Medical aircraft (and vehicles) took fire from Panamanian paramilitary forces (DIGBATS) during Operation JUST CAUSE. Center for Army Lessons Learned, Operation JUST CAUSE: Lessons Learned, p. III-14, (October 1990).

(3) By contrast, in the Falklands each of the hospital ships (British had 4; Argentines had 2) had one dedicated medical aircraft with red cross emblems. Radar ID was used to identify these aircraft because of visibility problems. Later it was done by the tacit agreement of the parties. Both sides also used combat helicopters extensively, flying at their own risk. No casualties occurred. Junod, PROTECTION OF THE VICTIMS OF THE ARMED CONFLICT IN THE FALKLANDS, ICRC, p. 26-27.

- d. Aircraft may be used permanently or temporarily on a medical relief mission; however, to be protected it must be used “exclusively” for a medical mission during its relief mission. Pictet, *supra*, at 289. This raises questions as to whether the exclusivity of use refers to the aircraft’s entire round trip or to simply a particular leg of the aircraft’s route. The point is overshadowed, however, by the ultimate need for an agreement in order to ensure protection. Pictet also says exclusively engaged means without any armament. *See also* article 28(3) in Protocol I; FM 8-10-6, *supra*, at A-3 (the mounting or use of offensive weapons on dedicated medevac vehicles and aircraft jeopardizes the protection afforded by the conventions. Offensive weapons include, but are not limited to, machine guns, grenade launchers, hand grenades, and light anti-tank weapons).
 - e. Reporting information acquired incidentally to the aircraft’s humanitarian mission does not cause the aircraft to lose its protection. Medical personnel are responsible for reporting information gained through casual observation of activities in plain view in the discharge of their duties. This does not violate the law of war or constitute grounds for loss of protected status. Dep’t of Army Field Manual 8-10-8, Medical Intelligence in a Theater of Operations para. 4-8 (7 July 1989). For example, a medevac aircraft could report the presence of an enemy patrol if the patrol was observed in the course of their regular mission and was not part of an information gathering mission outside their humanitarian duties.
 - f. Flights over enemy or enemy-occupied territory are prohibited unless agreed otherwise.
3. Summons to land.

- a. Means by which belligerents can ensure that the enemy is not abusing its use of medical aircraft - **must be obeyed**.
 - b. Aircraft must submit to inspection by the forces of the summoning Party.
 - c. If not committing acts contrary to its protected status, may be allowed to continue.
4. Involuntary landing.
- a. Occurs as the result of engine trouble or bad weather. Aircraft may be used by captor for any purpose.
 - b. Personnel are Retained or PWs, depending on their status.
 - c. Wounded and sick must still be cared for.
5. Inadequacy of GWS Article 36 in light of growth of use of medical aircraft prompted overhaul of the regime in GP I (Articles 24 - 31).
- a. Establishes three overflight regimes:
 - (1) Land controlled by friendly forces (Article 25): No agreement between the parties is required; however, the article recommends that notice be given, particularly if there is a SAM threat.
 - (2) Contact Zone (disputed area) (Article 26): Agreement required for absolute protection. However, **enemy is not to attack once aircraft identified as medical aircraft**.
 - (3) Land controlled by enemy (Article 27): Overflight agreement required. Similar to GWS, Article 36(3) requirement.
6. Optional distinctive signals (Protocol I, Annex I, Chapter 3), e.g. radio signals, flashing blue lights, electronic identification, are all being employed in an effort to improve identification.

VII. DISTINCTIVE EMBLEMS.

A. Emblem of the Conventions and Authorized Exceptions (Article 38).

- 1. Red Cross. The distinctive emblem of the conventions.

2. Red Crescent. Authorized exception.

3. Red Lion and Sun. Authorized exception employed by Iran, although has since been replaced by the red crescent.

B. Unrecognized symbols. The most well-known is the red “Shield of David” of Israel. While the 1949 diplomatic conference considered adding this symbol as an exception, it was ultimately rejected. Several other nations had requested the recognition of new emblems and the conference became concerned about the danger of substituting national or religious symbols for the emblem of charity, which must be neutral. There was also concern that the proliferation of symbols would undermine the universality of the red cross and diminish its protective value. Pictet, supra, at 301. In the various Middle East conflicts involving Israel and Egypt, however, the “Shield of David” has been respected. FM 8-10, supra, at para. 3-19.

C. Identification of Medical and Religious Personnel (Article 40).

1. Note the importance of these identification mechanisms. The two separate and distinct protections given to medical and religious personnel are, as a practical matter, accorded by the armband and the identification card. FM 8-10, supra, at para. 3-18.

a. The armband provides protection from intentional attack on the battlefield.

b. The identification card indicates entitlement to “retained person” status.

2. Permanent medical personnel, chaplains, personnel of National Red Cross and other recognized relief organizations, and relief societies of neutral countries (Article 40).

a. Armband displaying the distinctive emblem.

b. Identity card - U.S. uses DD Form 1934 for the ID cards of these personnel.

c. Confiscation of ID card by the captor prohibited. Confiscation renders determination of retained person extremely difficult.

3. Auxiliary personnel (Article 41).

- a. Armband displaying the distinctive emblem in miniature.
- b. ID documents indicating special training and temporary character of medical duties.

D. Marking of Medical Units and Establishments (Article 42).

1. Red Cross flag and national flag.
2. If captured, fly only Red Cross flag.

E. Marking of Medical Units of Neutral Countries (Article 43).

1. Red Cross flag, national flag, and flag of belligerent being assisted.
2. If captured, fly only Red Cross flag and national flag.

F. Authority over the Emblem (Article 39).

1. Article 39 makes it clear that the use of the emblem by medical personnel, transportation, and units is subject to “competent military authority.” The commander may give or withhold permission to use the emblem, and the commander may order a medical unit or vehicle camouflaged. Pictet, supra, at 308.
2. While the convention does not define who is a competent military authority, it is generally recognized that this authority is held no lower than the brigade commander (generally O-6) level. FM 8-10, supra, at para. 3-19.